

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155525</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 03/16/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SHADY NOOK CARE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>36 VALLEY DR LAWRENCEBURG, IN 47025</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00086221 completed on 2/24/11.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to Complaint IN00085670 investigated on February 4, 6 &amp; 7, 2011.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00087253.</p> <p>Complaint IN00086221- corrected.</p> <p>Survey dates: March 15 &amp; 16, 2011</p> <p>Facility number: 000304 Provider number: 155525 AIM number: 100266810</p> <p>Survey team: Leslie Parrett RN TC Barbara Gray RN Angel Tomlinson RN (March 16, 2011)</p> <p>Census bed type: SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 8 Medicaid: 52 Other: 12 Total: 72</p> <p>Sample: 6</p> <p>Shady Nook Care Center was found to be in</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 compliance with CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00086221.  Quality review completed on March 21, 2011 by Bev Faulkner, RN			{F 000}			